DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

OFFICIAL FILE COPY

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 — 0 0 1

2. STATE: Arkansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR, Part 435, Subpart B

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ -0-
b. FFY 2003 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 1 to Attachment 2.6-A, Page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same, Approved 10-25-01, TN 01-21

10. SUBJECT OF AMENDMENT:
The Arkansas Title XIX State Plan has been amended to add information in Item A.1 of Supplement 1 to Attachment 2.6-A, Page 1. This information was inadvertently omitted in TN 01-021.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Ray Hanley

14. TITLE:
Director, Division of Medical Services

15. DATE SUBMITTED:
January 8, 2002

16. RETURN TO:
Division of Medical Services
P. O. Box 1437
Little Rock, AR 72203-1437

Attention: Binnie Alberius
Slot XXXX S295

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JANUARY 14 2002

18. DATE APPROVED: FEBRUARY 13 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JANUARY 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:
Sandra Hall

21. TYPED NAME:
for CALVIN G. CLINE

22. TITLE: ASSOCAITE REGIONAL ADMINISTRATOR
DIV OF MEDICAID AND STATE OPERATIONS

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Calvin G. Cline
Associate Regional Administrator, Medicaid and State Operations

1301 Young Street, Room 827
Dallas, Texas 75202
Phone (214) 767-6301
Fax (214) 767-0270

February 13, 2002

Our Reference: SPA-AR-02-01

Mr. Ray Hanley, Director
Division of Medical Services – Slot 1103
Arkansas Department of Human Services
Post Office Box 1437
Little Rock, Arkansas 72203-1437

Dear Mr. Hanley:

We have enclosed a copy of HCFA-179, Transmittal Number 02-01, dated January 8, 2002. This amendment adds specific income eligibility limits for AFDC-Related groups other than poverty level pregnant women and infants that were inadvertently omitted from approved Arkansas SPA 01-21.

We have approved the amendment for incorporation into the official Arkansas State Plan effective January 1, 2002. If you have any questions, please call Bill Brooks at (214) 767-4461.

Sincerely,

Sandra Hall

for Calvin G. Cline
Associate Regional Administrator
Division of Medicaid and State Operations

Enclosure

cc: Elliott Weisman, CMSO

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

1. AFDC-Related Groups Other Than Poverty Level Pregnant Women and Infants:

Family Size	Need Standard	Payment Standard	Maximum Payment Amounts
1	$ 280.00	$ 81.00	$ 81.00
2	560.00	162.00	162.00
3	705.00	204.00	204.00
4	850.00	247.00	247.00
5	985.00	286.00	286.00
6	1,140.00	331.00	331.00
7	1,285.00	373.00	373.00
8	1,430.00	415.00	415.00
9	1,575.00	457.00	457.00

2. Pregnant Women and Infants under Section 1902(a)(10)(i)(IV) of the Act:

~~Effective April 1, 1990~~, based on the following percent of the official Federal income poverty level--

/X/ 133 percent* /_/ _____ percent (no more than 185 percent)
(specify)

Family Size	Income Level
1	$_____
2	$_____
3	$_____
4	$_____
5	$_____

* See Supplement 8a to Attachment 2.6-A, Page 2

SUPERSEDES TN- AR 01-21

STATE ARKANSAS
DATE REC'D 01-14-02
DATE APP'V'D 02-13-02
DATE EFF 01-01-02
HCFA 179 AR 02-01

A